

**FILED**

DECEMBER 9, 2004

**NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS**

STATE OF NEW JERSEY  
DEPARTMENT OF LAW & PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION  
OR REVOCATION OF THE LICENSE OF:

**MATTHEW PONZIO, M.D.**  
License MA 02335300

**Administrative Action**

**ORDER CONTINUING  
TEMPORARY SUSPENSION  
OF LICENSE**

TO PRACTICE MEDICINE AND SURGERY :  
IN THE STATE OF NEW JERSEY

This matter was initially heard before a Committee of the State Board of Medical Examiners on November 19, 2004 and November 22, 2004. The Committee entered an Order temporarily suspending the license of respondent Matthew Ponzio, M.D., to practice medicine and surgery in the State of New Jersey pending the completion of plenary proceedings in this matter (see Order Imposing Temporary Suspension of License, filed December 7, 2004, effective November 22, 2004, appended hereto and adopted in its entirety herein). The Order of the Committee, together with the record from the hearing, was presented to the full Board of Medical Examiners on December 8, 2004 for review, so as to afford the full Board an opportunity to determine whether to ratify, reject or modify the action taken by the Committee (see Order of Temporary Suspension of Licensure).

The full Board has reviewed the Order of the Committee and the record below, and unanimously votes to ratify and adopt, in its

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entirety, the Order of the Committee. The Board finds the reasoning of the Committee, outlined at length in the Committee's order, convincingly supports the Committee's conclusion, and now this Board's conclusion, that a palpable demonstration has been made that respondent's continued practice would present clear and imminent danger to public health, safety and welfare, and the concomitant conclusion that no measure short of the temporary suspension of respondent's license would be sufficient or appropriate in this case. The license of respondent Matthew Ponzio, M.D. , shall therefore continue to be temporarily suspended, pending the completion of plenary proceedings in this matter, for the reasons set forth at length in the Order of the Committee.

WHEREFORE, IT IS ON THIS 9<sup>TH</sup> DAY OF DECEMBER 2004

ORDERED :

1. The Board adopts, in its entirety, the Order of its Committee filed on December 7, 2004.

2. The license of respondent Matthew Ponzio, M.D. shall continue to be temporarily suspended, pending the completion of plenary proceedings in this matter or further Order of the Board.

NEW JERSEY STATE BOARD OF  
OF MEDICAL EXAMINERS

By: 

Bernard Robins, M.D., F.A.C.P.  
Board President

**FILED**

DECEMBER 7, 2004

**NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS**

STATE OF NEW JERSEY  
DEPARTMENT OF LAW AND PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION OR : Administrative Action  
REVOCATION OF THE LICENSE OF:

**MATTHEW R. PONZIO, M.D.  
LICENSE #MA 02335300**

**ORDER OF TEMPORARY  
SUSPENSION OF LICENSURE**

:  
TO PRACTICE MEDICINE AND SURGERY :  
IN THE STATE OF NEW JERSEY

This matter was opened to the New Jersey State Board of Medical Examiners on the application for a temporary suspension of respondent's license to practice medicine brought by Attorney General Peter C. Harvey, by Kevin Jespersen, Deputy Attorney General. An Order to Show Cause was signed by Bernard Robins, M.D., Board President on November 9, 2004 by which a hearing was scheduled for November 19, 2004. The hearing was held on November 19, 2004 and continued on November 22, 2004. Respondent was represented at the hearing by James Crawford Orr, Esq. and Susan Karlovich, Esq. who on November 15, 2004 filed an answer on respondent's behalf.

Respondent sought an adjournment of the proceeding, which Board President Robins determined could be granted only on condition that: respondent enter into an appropriate order agreeing to cease the practice of medicine pending a hearing on the application for temporary suspension. No such order was entered. The Committee convened at 9:00 a.m. on November 19, 2004 and the hearing continued until 10:55 p.m. on that date; the hearing continued from 10:00 a.m. on November 22, 2004 until its conclusion at 7:30 p.m.

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The State's Verified Complaint, Brief In Support of the Application For Temporary Suspension and Appendix including affidavits, certifications, hospital records' and a transcript of the testimony of respondent, filed simultaneously with the Order to Show Cause, alleges in nine (9) counts that respondent's continued practice of medicine poses a clear and imminent danger to the citizens of New Jersey and seeks an immediate temporary suspension of licensure pursuant to N.J.S.A. 45:1-22. The Attorney General generally charges that respondent, a cardiologist, has committed acts of gross and repeated negligence that exposed his patients to death and severe injury. Additionally, the application alleges that respondent engaged in deliberately deceptive conduct such as back dating and improperly altering his entries in patients' medical records and falsifying his medical credentials. By its brief and presentation, the Attorney General identified the particular allegations which provided the basis for the application for temporary suspension. Specifically, the Attorney General maintained that the following acts and practices demonstrated a course of conduct such that respondent's continued practice would pose a clear and imminent danger to the public:

1. Respondent failed to prescribe Plavix or aspirin for patient J.B. upon discharge after insertion of a stent into patient J.B.'s arteries following his suffering of a heart attack, and despite awareness that in 25 to 40% of all cases a stent will re-occlude without the use of aspirin and Plavix. Shortly after discharge, the patient suffered a myocardial infarction and later died.

2. Respondent cleared S.M., a 75 year old patient for elective hip replacement surgery without noting on the consultation report several serious conditions warranting further assessment prior to surgery including a marked abnormal electrocardiogram, that the patient had a portion of his left lung removed in prior surgery, that an x-ray report: noted scarring and fibrosis in both lungs, that the patient was taking Digoxin, a medication used to treat atrial fibrillation, and had a urinary tract infection prior to admission. Additionally respondent failed to obtain the results of a urine culture to confirm that the infection had abated prior to surgery. Following surgery the patient developed a wound infection and a clostridium difficile infection, suffered repeated heart attacks and expired.

3. Respondent ordered Dilantin in such extraordinary quantities for patient P.L. that the patient suffered Dilantin toxicity, became ataxic, (was staggering and could not walk). Respondent failed to consistently monitor the Dilantin levels in the patient's blood. Although Dilantin toxicity poses a risk of liver damage, the patient was discharged from the hospital without ordering additional Dilantin studies or liver function tests to assure that the patient did not suffer liver damage.

4. Respondent continued to prescribe Coumadin, an anticoagulant medication to patient M.M. who suffered from active gastrointestinal bleeding from multiple gastric ulcers, yet respondent failed to obtain any coagulation studies for the patient over a seventeen (17) day period while she was hospitalized. The INR (International Normalization Ratio) of the patient when eventually monitored indicated a dangerously slow rate of coagulation, such that the patient was at risk for substantial and uncontrolled bleeding. The failure to adequately monitor M.M. while on Coumadin threatened the patient's life.

5. Respondent assumed the care of patient B.B. who had chest pain upon admission to Mountainside Hospital. B.B., a patient weighing more than 400 pounds, began continuously complaining of severe pain in the groin which was sharp and continuous and rated an 8 out of 10 on the standard pain scale. Despite an examination indicating that the scrotum was swollen, and the prescription of Morphine and Percocet for the groin pain, respondent discharged the patient without taking action to determine the cause of pain or whether the patient was suffering from an infection. The day following discharge, patient B.B.

was readmitted to Mountainside Hospital with a diagnosis of cellulitis of the scrotum, a severe infection of the scrotum.

6. Respondent noted patient J.Q.'s vital signs were stable on February 17, 2003, a time when the patient experienced acute distress with a pulse rate of between 116 and 120, and a partial pressure of arterial oxygen of 47 with an alveolar to arterial gradient of several hundred (indicating that the patient's blood was severely oxygen deprived). Respondent failed to devise any plan for dealing with the acute distress of the patient. Moreover, although respondent noted the need for a Lumen Catheter, it was not inserted for many days. The patient was suffering from severe pulmonary dysfunction, a potentially life threatening condition, yet respondent failed to recognize the severity of the condition or devise any plan to deal with the acute distress which if it persisted untreated could have resulted in death.

7. Respondent repeatedly failed to record in his records for patients, including progress notes, discharge summaries and consultation reports, significant information with regard to patients' conditions and plans for treatment which could significantly affect their care, including:

a. respondent's consultation report described the lungs of patient S.M. as "perfectly normal", despite the fact that patient S.M. had undergone surgery to remove a portion of his left lung previously, and that an x-ray report notes scarring and fibrosis in both lungs; the consultation report suggested that the patient's heart functions were perfectly normal without noting a severely abnormal electrocardiogram, arrhythmia, and that the patient was receiving Digoxin, a medication used to treat atrial fibrillation.

b. As to patient B.B., respondent failed to note either the fact or the results of the examination of the scrotum of the patient, that the scrotum was swollen or that the patient was suffering continuous and severe pain in the groin area.

c. Respondent's notes for patient J.Q. indicate on February 17, 2003 that the patient's lungs were clear despite the fact that the patient

experienced acute distress and was suffering from severe pulmonary dysfunction.

The failure to record full and accurate descriptions of the patients' conditions and plans for treatment in appropriate records exposed the patients to the risk of substantial harm, impeded the coordination of care and hindered other health care providers from appropriately assessing and responding to patients' conditions.

8. Over a period of six months, Dr. Ponzio utilized letterhead containing the designation "F.A.C.C.", indicating that respondent was a fellow of the American College of Cardiology when he is neither a member nor a fellow of such college nor is eligible to use that designation which indicates the possession of certain education and experience and other criteria established by the college.

9. Respondent repeatedly altered and back dated entries in patients' medical records. Specifically, sometime after July 14, 2003 regarding patient A.D., respondent made entries into the progress notes for July 12 and July 13, 2004, and sometime after February 5, 2004 respondent altered an entry for February 3, 2004 and added an entry for February 4, 2004 in the progress notes regarding patient W.K.

Respondent's answer to the complaint acknowledged many of the factual allegations while denying many of the conclusions and all of the legal conclusions drawn therefrom.

At the time of hearing the Attorney General offered the testimony of Dr. Jan R. Weber, who was qualified as an expert in internal medicine and cardiology. In addition the Attorney General submitted thirty-two (32) items into evidence, Respondent offered testimony of Dr. John A. Russo, M.D. after qualifying him to give expert opinion in connection with the matters pending before the Board. Respondent also offered the testimony of Dr. Geralyn Ponzio, and submitted forty-three (43) exhibits, forty (40) of which where

admitted into evidence. A table of all exhibits appears at the conclusion of this document.

While respondent has sought to portray this matter as one grounded in a question of acceptable medical judgment in numerous difficult and complex medical cases, the State has maintained that the case rests on two theories - - first, that the pattern established by respondent's treatment of a number of patients indicates careless disregard for their welfare and gross malpractice rendering him an imminent danger to the public and second, that respondent's dishonesty, demonstrated in a number of arenas, exacerbates his poor judgment and increases the danger to the public due to his unreliability.

with respect to the care and treatment of the patients presented in this matter, the Attorney General presented the testimony of Dr. Jan Weber who among other credentials, is Board certified in both internal medicine and cardiology, He opined that in all six (6) of the patient cases, respondent exhibited grossly deficient medical judgment. Specifically, as to patient J.B., Weber opined that the failure to prescribe aspirin and Plavix, for the patient following insertion of a coronary stent, was life threatening and gross malpractice. J.B. was admitted to Mountainside Hospital with findings consistent with of an acute anterior myocardial infarction, and taken to the cardiac catheterization laboratory where coronary stents were inserted into the left interior descending coronary artery to re-establish blood flow in the vessel which was infarcting.

the patient had been premedicated with antiplatelet agents and given an intravenous anticoagulant during the procedure. These agents are given in an effort to try to prevent a clot from forming within the vessels or platelets from being activated at the site where the stent is being placed. Dr. Weber testified it has been demonstrated that the use of these agents have a strong beneficial impact on the patency of the vessel and that conventional therapy, as widely accepted in the medical community, the standard of care includes the provision of aspirin and Plavix, antiplatelet agents, to improve the likelihood the stent will remain open after its deployment. He opined that there is approximately a 30 to 40% percent chance that a vessel will re-occlude within six (6) months following its implantation presenting the risk of another myocardial infarction. Dr. Weber further verified, in agreement with respondent's admission to paragraph 8 of Count I of the Complaint, that the failure to treat with Plavix and aspirin exposes the patient to substantial risk that the stent will close and the patient will suffer a myocardial infarction (or heart attack).

Despite a mitigating situation presented that J.B. had a diagnosis of lung cancer, (indicating the use of an anticoagulant such as Plavix would have to be weighed against the potential risks of hemorrhagic complications from the presence of the neoplasm), as there was no evidence of any significant hemorrhagic complications and Dr. Weber agreed with the advice of the cardiologist who performed the procedure, that Plavix should be utilized and would

take precedence over any treatment that would otherwise be provided for the treatment of neoplasm.

Dr. Weber concluded that in absence of evidence of an absolute contraindication, which was not present here, it was a gross deviation from the standard of care to have failed to prescribe Plavix and aspirin for the patient and put his chemotherapy on hold to reduce the likelihood of in-stent thrombosis. He further opined that this was a life threatening deviation due to the 30 to 40 percent chance of re-stenosis - a substantial chance that a myocardial infarction would occur. Indeed the patient was readmitted to the hospital six (6) days following discharge with an acute myocardial infarction and eventually expired.

Dr. Weber also testified regarding the care and treatment of patient P.L. who had a history of seizure disorder. P.L. was admitted to Mountainside Hospital after a grand mal seizure and was treated by Dr. Ponzio following treatment in the emergency room where 1,000 milligrams of Dilantin and 500 milligrams of Depakote were administered. Dr. Ponzio treated this patient with an initial dose of 500 milligrams of Dilantin three (3) times per day which Dr. Weber opined was substantially higher than the traditional dose of 100 milligrams three (3) times per day after an initial loading dose. The 1.5 gram dose was continued for three days, and then lowered to 750 milligrams.

Dr. Weber testified, and the medical records in evidence substantiated, that it was important to monitor the Dilantin level

through laboratory tests to determine whether a sufficient amount is being provided or whether the patient is receiving too much of the medication. This is particularly important due to the danger of Dilantin toxicity, which has consequences which may include liver damage, toxic affects on the brain and cardiac systems, and neurological toxicity. Dr. Ponzio's discharge summary (Exhibit F) and the hospital records in this case demonstrate that the patient experienced Dilantin toxicity, including increased confusion, disorientation, memory difficulties, inability to walk or ambulate and other symptoms.

Dr. Weber opined that the care of patient P.L. was inconsistent with the standard of care as the dosage of Dilantin prescribed was excessive, and there was a failure to appropriately monitor Dilantin levels or liver enzymes to determine whether adverse liver toxicity was occurring. Dr. Weber termed the degree of deviation to be gross as the patient was put at substantial risk as a consequence of neurological aberrations that developed during the toxicity and the possibility that the patient could have suffered an injury due to inability to ambulate and impaired judgment.

The records and testimony in this case indicated that Dilantin levels were not measured from May 23, 2003 (when the level was measured at 19.1) until May 29, 2003 a time when the level was measured at 51.1, well beyond the toxic range and described by Dr. Weber as the highest level he has ever seen. The last level taken on the patient was on June 1, 2003 when a level of 38, above the upper

limits of toxic range was recorded, This was described by Dr. Weber as almost twice the accepted therapeutic range of 10 to 20, however the Dilantin level was not checked again prior to the patient being discharged from the hospital.

The deficiencies identified by Dr. Weber in the care of P.L. include the failure to check Dilantin levels daily to assure that the therapeutic level was reached and a toxic dose avoided, (as not checking is akin to "flying blind"), and administering Depakote to a patient that is suffering from Dilantin toxicity, as Depakote itself is associated with liver toxicity and can potentiate the effects of Dilantin. Additionally, the dosage of Dilantin being given was dangerously excessive, could be considered potentially lethal, but was not altered until after the pharmacy identified the dosage as being excessive on May 25, 2003. Finally, after the toxicity levels of Dilantin were identified, no additional liver function studies were ordered despite the fact that the medication has been associated with hepatotoxicity.

Dr. Weber further provided testimony regarding the care of patient S.M., who was admitted to Mountainside Hospital on February 9, 2004 for elective hip replacement surgery. Dr. Ponzio provided medical clearance for the patient in which he described the patient's lungs as "clear" and made no mention of any other pulmonary disease or pulmonary condition; and included his findings regarding the patient's heart which indicated there were no apparent cardiac abnormalities either by history or physical examination. However, x-

rays indicated that the patient had gone through a major thoracic procedure including removal of a portion of the left lung, and the presence of scarring and fibrosis in both lungs. An electrocardiogram indicated occasional atrial premature beats, a right bundle branch block, and the presence of Q waves in the inferior wall indicating the presence of scar tissue on the bottom surface of the heart (evidence the patient had a previous myocardial infarction).

Dr. Weber opined that in the presence of such extremely abnormal electrocardiographic findings and the results of the chest x-ray, a further evaluation of the patient's pulmonary functions along with further assessment of the patient's coronary circulation should be performed before the scheduling of an elective procedure.

Additionally, Dr. Ponzio's failure to disclose an acute urinary tract infection several days before the patient's admission for surgery and his failure to wait for the results of the urine culture before clearing the patient before surgery was critiqued by Dr. Weber. He indicated the presence of an infection in the bladder is an added concern when a patient is scheduled for an operation in close proximity to the urinary tract, as the greatest fear of any orthopedic surgeon is infection of the wound. Dr. Weber opined that the recommendation that his elective surgical procedure be performed without additional evaluation prior to the surgery exposed the patient to potential additional risks that could have been life threatening, which was a gross deviation.

The testimony of Dr. Weber continued in describing respondent's care of patient M.M. who was admitted on August 4, 2003 with active gastrointestinal bleeding. Dr. Weber was of the opinion that the treatment of this patient with Coumadin while failing to obtain coagulation studies Over a 17 day period from September 5<sup>th</sup> through September 22, 2003, (particularly in the face of an INR result: of 21.3 indicating an elevation of INR such that the Coumadin dosage was excessive and was producing a dramatic reduction of the patient's blood clotting ability) was not consistent with general standards of care in a patient with demonstrated ulcers and a tendency to severe hemorrhage. This was termed a gross deviation not only because the patient was at risk of increased hemorrhage, but as the INR level was demonstrated to have been elevated which would greatly increase the probability of a severe hemorrhage were the patient to suffer a fall or other type of trauma and as such levels are also associated with spontaneous bleeds which are life threatening.

Dr. Weber also testified regarding the care and treatment of patient B.B. by Dr. Ponzio. The 51 year old patient admitted to Mountainside on September 16, 2003 was morbidly obese (over 400 pounds) and was admitted with complaints of chest pain for several days: In addition to the admitting complaint, the patient experienced severe groin pain consistently during the hospitalization. Morphine was regularly prescribed for the patient's groin pain, with Percocet prescribed at the time of discharge. The patient was readmitted to Mountainside Hospital with a diagnosis of

cellulitis (a severe infection which includes the risk of an infectious organism spreading to the bloodstream which could produce sepsis and potentially lead to the demise of the patient) of the scrotum the day following discharge.

Dr. Weber indicated that the care of patient B.B. was a gross deviation from the standard, that it was unlikely that cellulitis had developed in the 24 hours between the time that the patient was discharged and readmitted, that it was the probable cause of the patient's severe pain, and that efforts to investigate the cause of the pain should have been performed such as by consultation with surgery, urology or infectious disease, or additional testing or studies. The deviation was considered gross as a condition such as a severe infection could have been potentially life threatening to the patient. Without knowing the cause of the pain it is inappropriate to send a patient home or analgesics without any definitive diagnosis or therapy.

Finally Dr. Weber testified regarding patient J.Q. who had a pulse rate of 116-120 on February 17, 2003 and a partial pressure arterial oxygen of 47 at 6:00 a.m. Dr. Ponzio's progress note for the same time indicated the patient's vital signs were stable. Dr. Weber averred that the records indicated that the patient had an episode of severe respiratory distress just prior to the time that the progress note was written, which was inconsistent with the condition of the patient as listed in Dr. Ponzio's note. Additionally he noted that Dr. Ponzio's treatment plan included *the*

need for the patient to receive a triple-lumen catheter which is used to monitor pressures within the pulmonary circuit, assess the degree of hydration of the patient and administer medications through a large bore access to the venous system. The record includes Dr. Ponzio's admission that the need for the device was first identified on February 17, 2003 but it was not installed until March 3, 2003. Dr. Weber was of the opinion that the failure to assure the installation of the catheter immediately was a gross deviation as the patient required a reliable mechanism for administration of intravenous medications to enable provision of timely administration of medications in an emergency. As this patient was quite unstable with the significant degree of pulmonary dysfunction, metabolic derangements, and the presence of an infectious process, Dr. Weber concluded that there was need for immediate access to the venous system for the provision of emergency medications.

Respondent presented the testimony of John A. Russo, M.D. who was Board certified in Internal Medicine and serves as a Section Chief in The Department of Internal Medicine at Saint Barnabas Hospital. Initially he voiced strong disagreement with Dr. Weber's findings as to respondent's care of the patients at issue, and particularly with the characterization that many of the cases involved gross malpractice. For example, as to patient P.L., Dr. Russo initially opined that there was no evidence of liver damage or liver toxicity, and that he did not believe it was true that there was grossly negligent mismanagement as the patient was clinically

improving, the "level" was coming down and liver function tests previous to this were normal. Re further disagreed that the patient should have been put back on the medications which he presented upon admission to the hospital, and opined that Dr. Ponzio "clearly went out of his way to assure that this patient, very, very difficult to manage, was managed properly."

However, upon questioning by Committee members, Dr. Russo acknowledged that he would train residents to closely monitor Dilantin levels; that the dosage of Dilantin for a seizure patient such as P.L. would be an initial loading dose of 800-1000 mg. followed by 100 mg. given three times per day; that he would have given less of a loading dose than the 1000 mg. given by the emergency room (ER) physician, and conceded the larger dosage of 1500 mg per day (500 mg. three times daily), given by respondent was unacceptable; which Russo described as a moderate deviation and higher than the dosage he would choose. Dr. Russo also agreed that it would be another deviation from the standard of care if respondent did not know of the initial ER loading dose of 1000 mg.; and that he disagrees with respondent's position that the pharmacy or nurse should have notified him that the dosage was too high as it is the primary physician (respondent) who is responsible, and who is at fault for the eventual Dilantin level of 51. Finally Dr. Russo agreed that as there was nothing in the chart to understand if the patient was still toxic, it can't be determined whether it was proper to discharge the patient.

Similarly, while initially voicing support for respondent's management of each of the patients, Dr. Russo eventually acknowledged serious, repeated, even "severe" deviations from the standard of care. As to patient B.B. Dr. Russo conceded he would not discharge a patient with scrotal pain at a level of 7 or 8 on the pain scale of ten, would want further studies if the cause of the pain was unknown; agreed that if there was a possibility the patient had a "serious" diagnosis and was discharged, the deviation would be "more serious," and finally that with a potential diagnosis of a "very serious" illness, discharging the patient represented a "severe" or gross degree of standard deviation.

Regarding the care of patient M.M., Dr. Russo acknowledged there was never a circumstance in which he would use Coumadin without having blood samples for INRs and to test PT (clotting factor) levels, agreed he would "absolutely" pay the utmost attention to the patient's INR due to the possibility of spontaneous bleeding; and that if the patient's family did not allow monitoring of the clotting factor, he would have stopped Coumadin, bloodwork and "everything."

As to patient J.B., although Dr. Russo testified he would not have placed a stent, he acknowledged that at the time the decision to stent was made the physicians must have considered the chance of bleeding was low or they would not have subjected the patient to the tremendous amount of medication needed to block the cardio system, and eventually agreed that the standard care for a patient who had a non-medicated stent placement during which large amounts of

antithrombotic medications were used, without the patient bleeding, would be to discharge the patient utilizing Plavix and aspirin for a three month period. He also agreed that as it would be contrary to both the standard of care and the consultation to stop Plavix in this case, he would have carefully documented his reasons for doing so. There was no such documentation in this case.

As to the consultation report provided by respondent to clear patient S.M. for surgery, Dr. Russo agreed in response to Board member questioning that if he saw this consultation as a teacher of first year residents he would send it back and require the student to rewrite it, admitted it was not an adequate clearance; that it is not acceptable to ignore EKG changes, x-ray findings and that the patient is diabetic or has impaired glucose tolerance. Finally he agreed it would be preferable to wait several weeks after an infection clears before surgery and that special care should be taken if a patient has been on antibiotics not to subject the patient to surgery unless they are very stable and free of infection for a reasonably long time. He agreed that the infection events in this record (which led to death) appeared to be related to an antibiotic used after the surgery.

Respondent also called Geralyn Ponzio, M.D., his daughter, who joined his practice and is employed by him full time since July of this year. She testified regarding various records she had retrieved for purposes of this proceeding, about certain procedures extant in respondent's office, and changes that have been instituted beginning

two (2) years ago and up to the present time. 11-24 for example, is a record obtained by Dr. Geralyn Ponzio from the Homestead, the residence of P.L., which demonstrates that P.L. had experienced seizures and that various medications were distributed to him prior to the hospital admission at issue. R-38 is a consultation which indicates that during a hospitalization prior to that at issue, J.B. had a workup for hemoptysis, The witness also testified that the reason respondent represented himself on stationery as possessing F.A.C.C. credentials he did not have, is that her mother, who is the office manager, placed the designation on his stationery after respondent told her he was "eligible" for F.A.C.C. As to respondent's office and general practices, the witness testified that in contrast to the past, her father is now dividing his office patient load with her, taking calls less frequently, sleeping and exercising on a regular basis, and seeing fewer hospitalized patients. She also conceded that respondent's recordkeeping was insufficient and that she has been striving for two years to institute a better system, succeeding about two weeks prior to the hearing to introduce a new progress note format to improve his recordkeeping. She acknowledged that respondent's recordkeeping has not included important items including the patient's complaint and the plan for treatment and in the past did not include the pertinent negatives or positives.

## DISCUSSION

Upon examination of the evidence before us, we are satisfied that the Attorney General has made a palpable demonstration that Dr. Ponzio's continued practice would present a clear and imminent danger to the public health, safety and welfare. The evidence thus supports a finding, at this juncture of the proceeding, that: Dr. Ponzio has demonstrated such a lack of judgment and careless disregard for the welfare of his patients that his continued practice poses an untenable risk to patients at this time. The demonstration that has been made thus far of Dr. Ponzio's repeated inadequate medical records, willingness to create back dated entries on hospital records and use of professional letterhead which misrepresented his credentials for over a 6 month period, only serves to underscore and highlight the inability of the committee to trust Dr. Ponzio to treat patients in New Jersey pending the outcome of this proceeding. The evidence before the Committee at this point in the proceeding revealed a pervasive pattern of deficiencies which posed grave risks to Dr. Ponzio's patients including the following:

- (1) Despite the grave risk for myocardial infarction, patient J.B. was discharged from the hospital following insertion of a stent without Plavix and aspirin being prescribed although they were utilized during his hospitalization. The purpose of placing a stent is absolutely defeated by failing to prescribe medication to reduce the risk of re-occlusion. Respondent's claim that the presence of hemoptysis prevented his prescribing of the medications is not supported by the present record, and the grave risk for myocardial infarction appears to be significantly greater than the risk from hemoptysis. The fact (cited by respondent in his defense) that this is a

complex case with multiple diagnose indicates that respondent should have been even more careful in his care of the patient.

(2) The failure to obtain coagulation studies for patient M.M., a patient at high risk for hemorrhage, over a 17 to 18 day period while she was hospitalized and continuing to use Coumadin, appears misguided and dangerous. Such medication is never used without the ability to monitor the patient. On this state of the record, we will not accept an after-the-fact attempt to utilize the family's deliberations about the care of the patient to justify the lack of monitoring, which constitutes a flagrant disregard for the well-being of the patient.

(3) Respondent's giving P.L. a super-dosage of Dilantin-500 milligrams a day, three times a day for three days, (reduced to 750 mg./day when informed by a pharmacist of the danger of the dosage), coupled with the failure to monitor the Dilantin levels sufficiently and the failure to recognize the toxicity prior to ordering Dilantin levels, leading to the patient's suffering of severe toxicity, constituted a wanton disregard of the welfare of this patient and subjected the patient to great risk and endangerment of life and health. Failing to check the hepatic toxicity of the patient despite evidence of Dilantin toxicity thereby not evaluating a potential severe side effect of Dilantin therapy, further endangered the life and/or health of the patient.

(4) Respondent endangered the life and safety of patient S.M. in issuing a preoperative clearance of the 75 year old patient for elective total hip replacement by failing to indicate in his report a severely abnormal chest x-ray and EKG therefore exposing the patient to the risk of perioperative morbidity and mortality. Listing the cardiac and lung systems as "normal" was either disingenuous or incompetent as the patient had a portion of his left lung removed in prior surgery, the chest x-ray report noted scarring and fibrosis in both lungs, and the patient had a markedly abnormal electrocardiogram. Additionally, the clearing of the patient without obtaining urine culture results given respondent's awareness of a recent urinary infection, exposed the patient to the risk of a recurrent infection. All of these circumstances risked the life or

safety of the patient and represent a severe lack of care, skill and/or honesty.

(5) Discharging patient B.B. from the hospital on narcotics, despite his suffering of severe groin pain (described as 8 out of 10 on a standard pain scale) and when the cause of the pain was undetermined, indicates poor judgment, lack of diagnostic acumen and indifference to the patient.

(6) The lack of documentation of severely abnormal vital signs such as the heart rate of patient J.Q. is consistent with the evidence of lack of thoroughness and inattention to significant clinical findings which is apparent in other matters before us. Such inattention to the significant abnormal clinical findings in this patient endanger the patient's health.

The Committee has concluded for purposes of this application for temporary suspension that the cumulative weight of the above set forth findings convinces us that Dr. Ponzio has demonstrated such a lack of judgment and careless disregard for the welfare of his patients in his approach to the practice of medicine in general that his continued practice would palpably constitute a clear imminent danger. His astonishing lack of attention to necessary laboratory monitoring of patients whose conditions require or whose therapies dictate such laboratory studies and monitoring is indicative of a cavalier attitude inconsistent with the safety of the public. Respondent's admitted improper falsification by the utilization of the terms "F.A.C.C." and the existing evidence of the back dating of patient records, at this juncture and on this record demonstrate dishonesty and misrepresentation which when coupled with the findings above of his lack of judgment leaves us with no alternative but to

temporarily suspend respondent's license. We therefore order' as indicated below subject to ratification by the full Board of Medical Examiners upon review of the transcript and full record of hearing in *this* matter,

**IT IS THEREFORE ORDERED EFFECTIVE ON THE ORAL ANNOUNCEMENT ON THE RECORD ON THE 22<sup>ND</sup> DAY OF NOVEMBER 2004:**

1. Respondent's license to practice medicine and surgery in the State of New Jersey shall be temporarily suspended as follows-

As of the oral announcement of this Order on the record, Respondent shall have no new patients and no new admissions to any hospital. He shall transfer all hospitalized patients within twenty-four (24) hours. He shall immediately begin to co-manage all office patients with Geralyn Ponzio, M.D. or another physician pre-approved by the Board. He shall have five (5) business days from November 22, 2004 until the close of business on December 1, 2004 to wind down his practice. Medical practice by respondent shall completely cease as of the close of business on December 1, 2004 and until completion of the plenary proceedings and review of such proceedings by the Board.

2. A motion for reentry into practice by respondent shall be entertained only upon respondent's demonstration to the satisfaction of the Board that he has met the following conditions:

a. Respondent shall undergo a focused evaluation at CPEP, the Center for Personalized Education of Physicians, following submission of background materials regarding this matter and respondent shall completely comply with any recommendations for re-education or other recommendations of that entity.

b. Respondent shall fully attend and successfully complete a recordkeeping course and an ethics course acceptable to and pre-approved by the Board.

c. Respondent shall make arrangements for a preceptor acceptable to the Board for co-management of all patients. Such preceptor may not be a relative.

d. Respondent shall agree that upon return to practice he shall report to the medical director of the Board for a chart review on a monthly basis.

e. Respondent shall upon return to practice limit his practice to no more than 40 hours per week at all sites.

3. In furtherance of this Order, respondent shall within ten (10) days of its service upon him, surrender his license and most recent biennial renewal card to Mr. William Roeder, at the Board of Medical Examiners officer, 140 East Front Street, P.O. Box 183, Trenton, New Jersey 08608, and shall fully comply with the Directives for Disciplined Licensees attached hereto and made a part hereof.

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

By: \_\_\_\_\_

Bernard Robins, M.D., President  
Committee Chair

Dec 7, 2004

## EXHIBITS

SE-1 M.M. Medical Records  
SE-2 J.B. Medical Records  
SE-3 J.Q. Medical Records  
SE-4 P.L. Medical Records  
SE-5 S.M. Medical Records  
SE-6 B.B. Medical Records  
SE-A Testimony of Dr. Ponzio  
SE-B J.B. Discharge Summary  
SE-C Physician Progress Notes for J.B.  
SE-D Report of Weber  
SE-E Coagulation Studies of M.M.  
SE-F P.L. Discharge Summary  
SE-G Physician's Order Form for P.L.  
SE-H Therapeutic Drug Monitoring for S.M.  
SE-I Consultation Report for S.M.  
SE-J X-Ray Report for S.M.  
SE-K Electrocardiogram Report for S.M.  
SE-L Nurses Notes for B.B.  
SE-M Physician's Progress Notes for B.B.  
SE-N Physician's Order form for B.B.  
SE-O History and Physical for J.Q.  
SE-P Physician's Progress notes for J.Q.  
SE-Q Physician's Progress Notes for J.B.  
SE-R Physician's Progress Notes for J.B.  
SE-S X-Ray Report for J.Q.  
SE-T Physician's Progress Notes for J.Q.  
SE-U Letter 5/20/04  
SE-V Affidavit of Randy Myslinski, R.N.  
SE-W Affidavit of Linda Wester, R.N.  
SE-X Letter 3/26/04  
SE-Y Curriculum Vitae of Dr. Weber

S-7 Letter to Susan Karklovich, Esq., from Kevin R. Jespersen, D.A.G., 9/20/04, 2 pages,

R-1 Saint Barnabas letter dated 7/26/04  
R-2 Anthony Oropollo letter re: Montclair Community Hospital dated 11/13/04  
R-3 Clara Maass Medical Center letter dated 11/15/04  
R-4 PBI Regional Medical Center letter dated 11/15/04  
R-5 Chilton Memorial Hospital letter dated 11/15/04  
R-6 St. Michael's Medical Center letter dated 11/15/04  
R-7 St. Vincent Hospital letter dated 11/15/04  
R-8 U. Mass Memorial letter dated 11/15/04  
R-9 Dr. Martin letter dated 11/16/04  
R-10 Dr. Epstein letter dated 11/4/04  
R-11 Certification of Eugene M.J. Pugatch, 11/18/04, 3 pages

**EXHIBITS (Continued)**

R-12      **Revised Saint Barnabas Progress Notes form**  
R-13      **Revised Clara Maass Progress Notes form**  
R-14      **Revised Chilton Memorial Progress Notes form**  
R-15      **Revised A&P by Organ System form**  
R-16      **Original Saint Barnabas Progress Notes form**  
R-17      **Original Clara Maass Progress Notes form**  
R-18      **Original Chilton Memorial Progress Notes form**  
R-19      **Saidi certification**  
R-20      **P.D.R. excerpt, 58 Ed., page 2531**  
R-21      **P.L. Discharge Summary (In record as SE-F)**  
R-22      **Mountainside Hospital Discharge Instruction form 6/3/03**  
R-23      **Dr. Matthew Ponzio office note on P.L., 6/4/03**  
R-24      **Resident Profile of P.L. (Homestead)**  
R-25      **Gentile Summary/P.L.**  
R-26      **Orsini certification**  
R-27      **Rombough certification**  
R-28      **Letter to Robert Barbalinardo, M.D. from Matthew R. Ponzio, M.D. 11/18/03, 2 pages.**  
R-29      **Curriculum Vitae of John A. Russo, M.D., 3 pages**  
R-30      **Combined Advance Directive for Health Care of M.M., 4/2/02, 6 pages**  
R-31      **Nursing Home Note re: M.M.'s Coumadin dose (identification only - withdrawn)**  
R-32      **Nurse's Note re: M.M.'s daughter that family wants to let her go (identification only - withdrawn)**  
R-33      **Physician's Progress Note re: M.M. (identification only - withdrawn)**  
R-34      **Dylantin administration records - Homestead**  
  
R-35      **Packet of original exhibits with stickers of Respondent's Exhibits, R-1 thru R-33, 48 pages**  
  
R-36      **Curriculum Vitae of Geralyn M. Ponzio, M.D.**  
R-37      **Mountainside Hospital x-ray reading of J.B., 10/24/03**  
R-38      **Mountainside Hospital consultation on J.B. by John Conti, M.D. 12/6/03, 3 pages**  
R-39      **Mountainside Hospital History & Physical of J.B., with attachments, 11/4/03, 5 pages**  
R-40      **Pathological workup packet, 10 pages**  
R-41      **Mountainside Hospital Operative Record on J.B., 11/5/03, 3 pages**  
R-42      **Computer Office Note on S.M., 12/22/03, 2 pages**  
R-43      **Patient charting samples, 5 pages**

**DIRECTIVES APPLICABLE TO ANY MEDICAL BOARD LICENSEE  
WHO IS DISCIPLINED OR WHOSE SURRENDER OF LICENSURE  
HAS BEEN ACCEPTED**

APPROVED BY THE BOARD ON MAY 10, 2000

All licensees who ~~are~~ the subject of a **disciplinary order of the Board** are required to provide the information required on the addendum ~~to~~ these directives. The information **provided will be maintained separately and** will not be part of the **public** document filed with the Board. Failure ~~to~~ provide the information required may result in further disciplinary action for **failing to cooperate with the Board, as required by N.J.A.C. 13:45C-1 et seq:** Paragraphs **1** through **4** below **shall apply when a license is suspended or revoked or permanently surrendered, with or without prejudice.** Paragraph **5** applies to licensees who are the subject of an order which, while permitting continued practice, contains a probation or monitoring requirement.

**1. Document Return and Agency Notification**

The licensee **shall** promptly forward to the Board office at Post Office **Box 183,140** East Front Street, **2nd** floor, Trenton, **New Jersey 08625-0183**, the original license, current biennial registration and, if applicable, the original CDS registration. In addition, if the licensee **holds a Drug Enforcement Agency (DEA) registration**, he or she shall promptly advise the **DEA** of the licensure action. (**With respect to suspensions of a finite term, at the conclusion of the term, the licensee may contact the Board office for the return of the documents previously surrendered to the Board. In addition, at the conclusion of the term, the licensee should contact the DEA to advise of the resumption of practice and to ascertain the impact of that change upon his/her DEA registration.**)

**2. Practice Cessation**

The licensee **shall cease and desist** from engaging in the practice of medicine in **this State. This prohibition not only bars a licensee from rendering professional services, but also from providing an' opinion as to professional practice or its application, or representing him/herself as being eligible to practice. (Although the licensee need not affirmatively advise patients or others of the revocation, suspension or surrender, the licensee must truthfully disclose his/her licensure status in response to inquiry.)** The **disciplined** licensee is also **prohibited from occupying, sharing or using office space in which another licensee provides health care services.** The disciplined licensee may contract for, accept payment from another licensee for or rent at fair market value office premises and/or equipment. **In no case may the disciplined licensee authorize, allow or condone the use of his/her provider number by any health care practice or any other licensee or health care provider.** **(In situations where the licensee has been suspended for less than one year, the licensee may accept payment from another professional who is using his/her office during the period that the licensee is suspended, for the payment of salaries for office staff employed at the time of the Board action.)**

**A licensee whose license has been revoked, suspended for one (1) year or more or permanently surrendered must remove signs and take affirmative action to stop advertisements by which his/her eligibility to practice is represented. The licensee must also take steps to remove his/her name from professional listings, telephone directories, professional stationery, or billings. If the licensee's name is utilized in a group practice title, it shall be deleted. Prescription pads bearing the licensee's name shall be destroyed. A destruction report form obtained from the Office of Drug Control (973-504-6558) must be filed. If no other licensee is providing services at the location, all medications must be removed and returned to the manufacturer, if possible, destroyed or safeguarded. (In situations where a license has been suspended for less than one year, prescription pads and medications need not be destroyed but must be secured in a locked place for safekeeping.)**

### **3. Practice Income Prohibitions/Divestiture of Equity Interest in Professional Service Corporations and Limited Liability Companies**

**A licensee shall not charge, receive or share in any fee for professional services rendered by him/herself or others while barred from engaging in the professional practice. The licensee may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of the Board action.**

**A licensee who is a shareholder in a professional service corporation organized to engage in the professional practice, whose license is revoked, surrendered or suspended for a term of one (1) year or more shall be deemed to be disqualified from the practice within the meaning of the Professional Service Corporation Act. (N.J.S.A. 14A:17-21). A disqualified licensee shall divest him/herself of all financial interest in the professional service corporation pursuant to N.J.S.A. 14A:17-13(c). A licensee who is a member of a limited liability company organized pursuant to N.J.S.A. 42:1-44, shall divest him/herself of all financial interest. Such divestiture shall occur within 90 days following the entry of the Order rendering the licensee disqualified to participate in the applicable form of ownership. Upon divestiture, a licensee shall forward to the Board a copy of documentation forwarded to the Secretary of State, Commercial Reporting Division, demonstrating that the interest has been terminated. If the licensee is the sole shareholder in a professional service corporation, the corporation must be dissolved within 90 days of the licensee's disqualification.**

### **4. Medical Records**

**If, as a result of the Board's action, a practice is closed or transferred to another location, the licensee shall ensure that during the three (3) month period following the effective date of the disciplinary order, a message will be delivered to patients calling the former office premises, advising where records may be obtained. The message should inform patients of the names and telephone numbers of the licensee (or his/her attorney) assuming custody of the records. The same information shall also be disseminated by means of a notice to be published at least once per month for three (3) months in a newspaper of general circulation in the geographic vicinity in which the practice was conducted. At the end of the three month period, the licensee shall file with the Board the name and telephone number of the contact person who will have access to medical records of former patients. Any change in that individual or his/her telephone number shall be promptly reported to the Board. When a patient or his/her representative requests a copy of his/her medical record or asks that record be forwarded to another health care provider, the**

licensee **shall** promptly **provide** the **record without charge** to the **patient**.

## **5. Probation/Monitoring Conditions**

With respect to any licensee **who** is the **subject of any** Order imposing a **probation** or monitoring requirement, **or** a stay of an active suspension, in **whole** or in part, which is conditioned upon compliance **with** a probation or monitoring requirement, the licensee shall fully cooperate with the Board and its designated representatives, including the Enforcement **Bureau of the Division of Consumer Affairs**, in ongoing monitoring of the licensee's status **and** practice. Such monitoring **shall be at the** expense of the disciplined practitioner.

(a) Monitoring of practice **conditions may** include, but **is** not limited to, inspection of the professional **premises and** equipment, **and inspection and copying** of patient records (confidentiality of patient identity **shall be protected by** the Board) to verify compliance with the Board **Order and** accepted standards of practice.

(b) Monitoring of status conditions for an **impaired** practitioner **may** include, but **is** not limited to, practitioner cooperation in providing releases permitting unrestricted access to **records** and other information to the extent permitted **by** law from any treatment facility, other treating practitioner, support group or other individual/facility involved in the education, treatment, monitoring or oversight of the practitioner, or maintained **by a** rehabilitation program for **impaired** practitioners. **If bodily** substance monitoring **has** been ordered, the practitioner **shall fully** cooperate **by** responding to a demand **for** breath, blood, urine **or** other sample in a timely manner **and** providing the designated sample.

## ADDENDUM TO SHE DIRECTIVES

Any licensee who is the subject of an **order** of the Board suspending, revoking or otherwise **conditioning** the **license**, **shall provide the following** information **at the time that the order is signed**, if it is entered by consent, *or immediately* after service of a fully executed order entered after a hearing. The information required here is necessary for the Board to fulfill its reporting obligations:

Social Security Number': \_\_\_\_\_

List the name **and** address of any and all Health Care Facilities with which you **are affiliated**:

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List the names and addresses of any and all Health Maintenance Organizations with which **you** are affiliated:

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**Provide** the **names and addresses of** every person **with whom you are** associated in your professional practice: (You **may attach a** blank sheet of **stationery** bearing this information).

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<sup>1</sup> Pursuant to 45 CFR Subtitle A Section 61.7 and 45 CFR Subtitle A-Section 60.8, the **Board is** required to obtain your Social Security Number and/or federal **taxpayer** identification number **in order to** discharge **its** responsibility **to report** adverse actions to the National Practitioner Data Bank **and** the HIP Data Bank.

**NOTICE OF REPORTING PRACTICES OF BOARD**  
**REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which **revokes or** suspends (or otherwise restricts) a license,
- (2) Which **censures, reprimands or** places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.